Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RAZVAN SCOBERCEA, MD
7401 SOUTH MAIN
HOUSTON TX 77030

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2396-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: NA

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier stands on the denial of reimbursement for the charges made the basis of this medical dispute."

Response Submitted by: Pappas & Suchma, P.C., PO BOX 66655, Austin, Texas 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 22, 2010	99455-VR	$50.00	$50.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December15, 2010

- 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES
- BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PAYMNT REQUESTS, SUMIT A COPY OF HIS EOR OR CLEAR NOTATION THAT A REC

Explanation of benefits dated February 24, 2011

- 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES
- BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL

Issues

1. Has the Treating Doctor's Agreement or Disagreement with Another Doctor's Certification been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(6), "The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and Division Rules, Chapter 130 of this title. The treating doctor shall bill using CPT Code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50." Also, Per 28 Texas Administrative Code §134.204(n)(10) states "VR, Review report--This modifier shall be added to CPT Code 99455 to indicate that the service was the treating doctor's review of report(s) only." Requestor as the treating doctor has performed a review of the examining doctor's Maximum Medical Improvement/Impairment (MMI/IR) exam and therefore has billed appropriately. The Respondent used a denial reason "59 - PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES". This code is not global to any service and the denial is unsupported.
2. Review of the submitted documentation finds that the DWC-69 was filled in correctly in Part V, titled "Treating Doctor's Agreement or Disagreement with Another Doctor's Certification". Therefore, the total allowable for CPT code 99455-VR is $50.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $50.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $50.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 07, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.